

APPLICATION FOR CERTIFICATION TO PROVIDE LIMITED SERVICES TO A PERSON UNDER SELF-ADMINISTERED SERVICES

Acquired Brain Injury Waiver

Form Number: 2-9C ABIW

Version Date: January 2021

General Information

Employee Name:

Social Security Number:

Phone Number:

Address: Include City, State, and Zip Code.

Name of PERSON receiving services:

Requested service: Check all that apply.

CH1

CO1

HS1

PA1

RP1

RP6

SL1

DTP

Knowledge Requirements for Certification

Employment Agreement

Date:

Department of Human Services Provider Code of Conduct

Date:

DIVISION Code of Conduct

Date:

Emergency Contact Information

Date:

PERSON'S Support Book or Daily File

Date:

Service Specific Training

Date:

Incident Reporting

Date:

Behavior Management

Date:

Acquired Brain Injury Info Packet (Training Manual Module 1)

Date:

Employee and Employer Signatures

I represent that I have read and am familiar with the above-identified materials and that I have been oriented to and/or trained on all of the materials by the EMPLOYER on the dates indicated. I further represent that I both understand and will comply with the requirements identified in the materials when providing services to the PERSON and that I am capable of providing appropriate services to the PERSON.

EMPLOYEE Signature:

Date:

I represent that I am the EMPLOYER and that I am familiar with both the above-identified materials and the supports required by the PERSON. I further represent that I provided orientation and/or training to the EMPLOYEE on all of the above required materials on the dates indicated above. I further represent that based on the training and orientation provided to the EMPLOYEE, I am satisfied that the EMPLOYEE has the knowledge, understanding and ability to provide appropriate services to the PERSON.

EMPLOYER Signature:

Date:

Award of Certification

Based on the forgoing representations of the EMPLOYEE and the EMPLOYER, the EMPLOYEE has met the minimum requirements necessary for Certification to Provide Limited Services to the PERSON receiving Self-Administered Services. The DIVISION, therefore, awards the EMPLOYEE certification to provide the following services to the PERSON.

Approved service: Check all that apply.

CH1

CO1

HS1

PA1

RP1

RP6

SL1

DTP

Support Coordinator Signature:

Date: